

ATTACHMENT E

- ☐ **Claim Processing**

Chafee Foster Care Independence Program (CFCIP)

All Client-Based Services (except CFCIP)

- ☐ **Documentation**

- ☐ **Allocations (allocations will be sent under separate cover)**

- ☐ **Provider Data Form**

- ☐ **W-9 Form**

- ☐ **Direct Deposit Form**

- ☐ **Minority and Women's Business Enterprise (MBE/WBE)**

- ☐ **Time Table**

Claim Process for Chafee Independent Living Program (CFCIP):

When the contract is fully executed, notice will be sent to Claims Management Services (CMS)

CMS will send claims for every month of the contract term to the grantee. Manual claims for revisions or corrections needed are also included.

Accounting Bulletin 149A (Revised 6/92) updates procedures to be used in the preparation of Claim Vouchers that are submitted for payment.

The vendor name and address should be completed in uppercase letters. The following account is to be used for regional services:

FUND: 3630
OBJECT: 573100
CENTER: 150500

The following Account codes should be used for Room and Board Expenses:

FUND: 3630
OBJECT: 573400
CENTER: 150500

- Contract Agreement number and claim ID must be included in description column of claim. These numbers can be found in the upper left-hand corner of the contract's Attachment A.
- Claims for all other eligible youths will be billed at 80% through Chafee funds. This is the only amount that can be claimed under this contract. As in the past, the remaining 20% will be billed to the county and will not be paid through this contract. Claims are to be billed under Service Code 1515.
- Claims for youth ages 18 to 21 that are no longer wards will be billed at 100% because the state will automatically pay the match to your agency. Claims for this age youth is to be made with the following service code: Service Code 1514
- A data sheet showing the following must be attached to the Room and Board Claim:
 - 1) Name of Youth
 - 2) Date of Birth
 - 3) County of Wardship
 - 4) Date Wardship terminated
 - 5) Specific room and board services received (rent, utilities, food, laundry), amount and date
 - 6) Either proof of payment if seeking reimbursement or proof of amount due by invoice, bill, etc,
 - 7) Source of Match

Grantee must prepare claims and submits to the Regional Child Welfare Services Coordinator within 45 days of the provision of service.

The Regional Child Welfare Services Coordinator checks that the claim is appropriately billed to the most restrictive funding source as well as captures certain data from the claim and submits it to CMS within 60 days of the provision of services. Any claims received by CMS after 60 days of the provision of services must be accompanied by a justification letter as to the reason for lateness of the claim. Claims submitted over 60 days of the provision of services may not be paid.

CLAIMS PROCESSING FOR ALL CLIENT-BASED SERVICES except CFCIP

When the contract is fully executed, notice will be sent to Claims Management Services (CMS)

CMS will send claims for every month of the contract term to the grantee. Manual claims for revisions or corrections needed are also included.

Grantee prepares claims and submits to the Regional Child Welfare Services Coordinator within 45 days of the provision of service

The Regional Child Welfare Services Coordinator checks that the claim is appropriately billed to the most restrictive funding source as well as captures certain data from the claim and submits it to CMS within 60 days of the provision of services. **Any claims received by CMS after 60 days of the provision of services must be accompanied by a justification letter as to the reason for lateness of the claim. Claims submitted over 60 days of the provision of services may not be paid.**

CMS pays the claim (usually within 2 weeks)

THE REGIONAL CHILD WELFARE SERVICES COORDINATOR ACTS ON THE CLAIMS AND RETURNS THEM TO THE GRANTEE VERY QUICKLY. THE COORDIANTOR RECOGNIZES THAT PROMPT PAYMENT IS IMPORTANT.

DOCUMENTATION

Grantees are expected to maintain records that document service delivery. For client-based services, records should be maintained on a client-specific basis. In the event of an audit or program evaluation, the auditor or evaluator must be able to support services claimed by service delivery documentation.

Documentation includes the amount of time spent in service delivery, the date of service delivery, and the specific activities that were delivered. For example, a case management home-based therapy hour should be documented by the date, time of day, name of client, address where the face to face contact took place, and the activity(ies) that occurred. Example: “discussed the client’s plan for spending more time with her children”.

For services that are not client based like foster parent recognition or group delivered child abuse and neglect activities, it is expected that the following supporting documentation be present: date, place, list of attendees, and curriculum or agenda for the event.

All client-based services are expected to have a client-specific referral from the Department of Child Services.

FSSA PROVIDER DATA FORM

This form, with the applicable W9 Form, must be submitted to the FSSA Program Area and forwarded to FSSA Contract Management **PRIOR** to the preparation of **ANY** contract. Allow Contract Management 7 days to verify and enter

| | |
|--|--|
| FSSA Program Name: _____ | Submitted on: _____ |
| Provider Contact Person: _____ | Telephone: () _____ |
| Fax Number: _____ | E-mail Address: _____ |
| Provider's Legal Name: _____ | |
| Provider's d/b/a Name: _____ (doing business as) | |
| Provider's FID/EIN/SSN: _____ | NOTE: SSN may only be used if the legal name above is an individual's name. |
| Provider's Legal Status: | |
| _____ Individual/Sole Proprietor | Indicate: <input type="checkbox"/> For-Profit <input type="checkbox"/> Nonprofit |
| _____ Corporation | Indicate: <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Town <input type="checkbox"/> Township <input type="checkbox"/> Other |
| _____ Government | |
| _____ Limited Liability Company | |
| _____ Partnership | Is it a LLP? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | List all partners: _____ |
| _____ School Corp. | Indicate list # as assigned by the Dept. of Education # _____ |

| | | |
|--|---|---------------------------------|
| Director/Manager: | Name: _____ | Title: _____ |
| Office/Street Address: (Main Location) | Street: _____ | County: _____ |
| | City: _____ | State: _____ |
| | Zip Code: _____ | |
| | Confidential Address? <input type="checkbox"/> Yes <input type="checkbox"/> No | Internet Address: _____ |
| | Phone#: () _____ | Phone#: () _____ |
| | Fax#: () _____ | Toll-Free#: () _____ |

| | | |
|-------------------------|--------------------------|---------------------|
| Mailing Address: | Street/POB: _____ | |
| | City: _____ | State: _____ |
| | Zip Code: _____ | |

| | | |
|--|------------------------|---------------------|
| Claims Payment Address Street: | _____ | _____ |
| <small>This address is where checks will be mailed. EVERYONE MUST attach a W9 Form reflecting this address regardless of legal status.</small> | City: _____ | State: _____ |
| | Zip Code: _____ | |

How frequently do you wish to claim for reimbursement? ☐ Monthly - 12 claims ☐ Semi-Monthly - 24 claims

Term of Contract Requested: _____

County(ies) for which funding is requested. Circle all that apply.

| | | | | | | | |
|----------------|-------------|---------------|--------------|---------------|---------------|----------------|------------------------------------|
| 01 Adams | 13 Crawford | 25 Fulton | 37 Jasper | 49 Marion | 61 Parke | 73 Shelby | 85 Wabash |
| 02 Allen | 14 Daviess | 26 Gibson | 38 Jay | 50 Marshall | 62 Perry | 74 Spencer | 86 Warren |
| 03 Bartholomew | 15 Dearborn | 27 Grant | 39 Jefferson | 51 Martin | 63 Pike | 75 Starke | 87 Warrick |
| 04 Benton | 16 Decatur | 28 Greene | 40 Jennings | 52 Miami | 64 Porter | 76 Steuben | 88 Washington |
| 05 Blackford | 17 Dekalb | 29 Hamilton | 41 Johnson | 53 Monroe | 65 Posey | 77 Sullivan | 89 Wayne |
| 06 Boone | 18 Delaware | 30 Hancock | 42 Knox | 54 Montgomery | 66 Pulaski | 78 Switzerland | 90 Wells |
| 07 Brown | 19 Dubois | 31 Harrison | 43 Kosciusko | 55 Morgan | 67 Putnam | 79 Tippecanoe | 91 White |
| 08 Carroll | 20 Elkhart | 32 Hendricks | 44 LaGrange | 56 Newton | 68 Randolph | 80 Tipton | 92 Whitley |
| 09 Cass | 21 Fayette | 33 Henry | 45 Lake | 57 Noble | 69 Ripley | 81 Union | |
| 10 Clark | 22 Floyd | 34 Howard | 46 Laporte | 58 Ohio | 70 Rush | 82 Vanderburgh | |
| 11 Clay | 23 Fountain | 35 Huntington | 47 Lawrence | 59 Orange | 71 St. Joseph | 83 Vermillion | |
| 12 Clinton | 24 Franklin | 36 Jackson | 48 Madison | 60 Owen | 72 Scott | 84 Vigo | <input type="checkbox"/> Statewide |

Is this a female-owned business? ☐ Yes ☐ No

Is this a minority-owned* business? ☐ Yes ☐ No _____ %

Is there minority participation**? ☐ Yes ☐ No _____ %

*If minority ownership amounts to 51% or more of the company, answer "yes" and enter 100%.

**If not minority-owned, enter % of minority participation.

| | |
|--|----------|
| Name/Title of persons authorized to sign legal documents and contracts. | |
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Taxpayer Identification Number Request

State of Indiana

W-9

DO NOT send to IRS

| | |
|---|--|
| Print or Type | Return to address below |
| Legal Name (OWNER OF THE EIN OR SSN AS NAME APPEARS ON IRS OR SSN RECORDS) DO NOT ENTER THE BUSINESS NAME OF A SOLE PROPRIETORSHIP ON THIS LINE | |
| Trade Name Complete only if doing business as (D/B/A) | |
| Remit Address | |
| Purchase Order Address- Optional | |
| Check legal entity type and enter 9 digit taxpayer Identification Number (TIN) below: (SSN = Social Security Number, EIN = Employer Identification Number) | SSN or EIN must be for legal name above. |
| <input type="checkbox"/> Individual (Individual's SSN) ____ - ____ - ____ | |
| <input type="checkbox"/> Sole Proprietorship (Owner's SSN or Business EIN) SSN ____ - ____ - ____ EIN ____ - ____ - ____ | |
| <input type="checkbox"/> Partnership <input type="checkbox"/> General <input type="checkbox"/> Limited (Partnership's EIN) ____ - ____ - ____ | |
| <input type="checkbox"/> Estate / Trust (Legal Entity's EIN) ____ - ____ - ____ Note: Show the name and number of the legal trust, or estate, not personal representatives. | |
| <input type="checkbox"/> Other (Limited Liability Company, Joint Venture, Club, etc) (Entity's EIN) ____ - ____ - ____ | |
| <input type="checkbox"/> Corporation Do you provide legal or medical services? <input type="checkbox"/> Yes <input type="checkbox"/> no (Corp's EIN) ____ - ____ - ____ | |
| <input type="checkbox"/> Government (or Government operated entity) (Entity's EIN) ____ - ____ - ____ | |
| <input type="checkbox"/> Organization Exempt from Tax under Section 501(a) (Org's EIN) ____ - ____ - ____ Do you provide medical services? <input type="checkbox"/> Yes <input type="checkbox"/> no | |
| <input type="checkbox"/> Check here if you do not have a SSN or EIN but have applied for one. | |

Under penalties of perjury, I certify that:

- (1) The number listed on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) AND
- (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends or (c) the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, and acquisition or abandonment of secured property, contribution to an individual retirement arrangement (IRA), and payments other than interest and dividends.)

CERTIFICATION INSTRUCTIONS -You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return.

THE IRS DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

I am a U.S. person (including a U.S. resident alien).

| | |
|----------------------------|------------------------|
| NAME (Print or Type) _____ | TITLE _____ |
| AUTHORIZED SIGNATURE _____ | DATE _____ PHONE _____ |

| | | | |
|--------------|-------------------------|--|--------------------|
| Agency _____ | Agency use only 1099 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Approved by: _____ |
|--------------|-------------------------|--|--------------------|

MINORITY AND WOMEN'S BUSINESS ENTERPRISE PARTICIPATION PLAN

An offeror is expected to submit in each response a Minority Business & Women's Enterprise Participation Plan in accordance with 25 IAC 5 and IC 4-13-16.5. In the Plan, the offeror must show that there are racial minorities and woman owned enterprises participating in the proposed contact. While the participation may be as a subcontractor, second tier participation with common suppliers (e.g., office suppliers, courier services) is acceptable. Respondents must indicate the name of the racial minority owned firm(s) with which it will work; the contact name and phone number at the firm(s); the service supplied by the firm(s); and the specific dollar amount from this contact that will be directed toward each firm. If the goal for this solicitation cannot be directed toward racial minority or woman owned enterprises, the respondent may demonstrate that a minimum of an amount equal to the goal of overall annual proceeds from all business are directed to racial and woman owned enterprises. Please note: If the Trade is an overhead item for your entire business, please calculate the proportion of the business that will actually apply to the solicitation in question.

Failure to provide the Plan at the time of proposal submission may result in the disqualification and rejection of the offer. The Indiana Department of Administration reserves the right to verify all information included in the Minority and Women Business Enterprise Participation Plan before making final determination of the offeror's responsiveness and responsibility.

An offeror may submit an application for a program waiver if the indicated goal or no participation is met. The offeror should demonstrate a good faith effort to meet the goal for example by working with the Minority and Women Business Development office of the Indiana Department of Administration to design a plan to meet the goal in an acceptable time period. Should those efforts not produce the goal, the waiver application may be submitted with documentation of the good faith effort. The State reserves the right to accept, verify or deny any application for waiver from the contact goal.

By submission of the offer, the offeror thereby acknowledges and agrees to be bound by the regulatory processes involving the State of Indiana's Minority Business Enterprise Program. Questions involving the regulations governing the Minority and Women Business Enterprise Participation Plan and/or the application for relief from the goal should be directed to the Compliance Manager of the Minority and Women's Business Enterprise Development office at 317/233-6607

MBE / WBE PARTICIPATION PLAN

RFP # _____ DUE DATE _____
 RFP NAME _____
 OFFEROR _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 PHONE() _____

The following minority owned firms will be participating in the RFP according to the following schedule:

| <u>MBE / WBE</u> | <u>PHONE</u> | <u>CONTACT</u> | <u>TRADE</u> | <u>AMOUNT</u> |
|-------------------------|---------------------|-----------------------|---------------------|----------------------|
|-------------------------|---------------------|-----------------------|---------------------|----------------------|

| | | | | |
|--|--|--|--|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please indicate which firms are MBE and which are WBE

***If additional room is necessary, please attach a separate page**

THIS DOCUMENT MUST BE INCLUDED IN YOUR PROPOSAL

APPLICATION FOR MBE / WBE PROGRAM WAIVER

Application for MBE / WBE Program Waiver is hereby submitted for the RFP listed below.

DATE OF APPLICATION _____/_____/_____

RFP # _____

RFP NAME _____

OFFEROR _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE () _____

Please indicate reason(s) for application below:

____ Unable to locate MBE/WBE engaged in _____

____ Unable to secure competitive price in _____

____ Other (see attached description)

Please indicate MBE/WBE firms contacted below:

| <u>MBE/WBE</u> | <u>TYPE OF ATTEMPT</u> | <u>DATE(S) ATTEMPTED</u> | <u>RESULTS</u> |
|----------------|------------------------|--------------------------|----------------|
|----------------|------------------------|--------------------------|----------------|

[illegible]

Please indicate which firms are MBE and which are WBE
***If additional room is necessary, please attach a separate page**

APPLICANTS SIGNATURE

DATE

THIS DOCUMENT MUST BE INCLUDED IN YOUR PROPOSAL

**2006-2008 TIME TABLE
CHILD WELFARE SERVICES PLANNING DOCUMENT**

| | | |
|-----------------------------------|--|--|
| January to August 19, 2005 | Planning document will be updated with service standards all reviewed and updated, new service standards written for mediation and parent education and others that may be needed, score sheets updated, and RFF developed for posting. RFF Boilerplate and score sheet developed | |
| August 22, 2005 | Planning Document and Proposal Materials sent to Regional Managers, DCS Directors, and others for review. | |
| September 2, 2005 | Planning Document and Proposal Materials approved and signed off by Central Office | |
| September 12, 2005 | Bidder's Conference held to discuss the upcoming RFF. | |
| September 15, 2005 | Contract Request with Special Conditions submitted to DCS Contract Management. Legal provided information to start developing contract to be included in the RFF. | |
| October 7, 2005 | Program Allocation Development FSSA Budget Allocation | |
| November 15, 2005 | Program RFF Released Electronically | Contract to Attorney General for form approval |
| November 15-23, 2005 | Questions provided in writing from prospective vendors | |
| December 1, 2005 | Regional Managers Meeting | |
| December 7, 2005 | Committee meets to write answers to questions. Answers to vendor questions posted on website. | |
| December 22, 2006 | Office of General Counsel Boilerplate Language Approved | |
| December 22, 2005 | Grantee Returns Proposal for contract | Attorney General Form Approval |
| January 20, 2006 | Proposals sent to County Directors for scoring. Negotiations take place between counties and agencies. | |
| January 27, 2006 | Scored proposals go to Regional Manager for review and approval. | |
| February 3, 2006 | Scored proposals are sent to Child Welfare Coordinators for preparation of 660s. Attachment A for contracts reviewed by Coordinators. | |
| March 3-24, 2006 | 660s received by Contract Coordination for entry into CMS. Attachments prepared. (8 weeks) | |
| March 31, 2006 | Contract developed and sent to grantee | |
| April 14, 2006 | Grantee returns contract | |
| April 18, 2006 | Executive Document Summary attached | |
| April 24, 2006 | Contract Administration Review | |
| April 28, 2006 | Division Director Signature | |
| May 2, 2006 | To FSSA Contract Tracking | |
| May 16, 2006 | Department of Administration signoff | |
| May 20, 2006 | State Budget Agency signoff | |
| May 25, 2006 | From: FSSA Contract Tracking | |
| May 2006 | To Division | |
| June 1-15, 2006 | Contracts fully executed with copy of contract sent to vendor | |